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VIA ELECTRONIC SUBMISSION

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

RE: Payment Policies under the Physician Fee Schedule; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; etc (CMS-1654-P)

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the proposed rule on Payment Policies under the Physician Fee Schedule; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; etc (CMS-1654-P). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights serves over two million beneficiaries, family caregivers, and professionals through its national helpline and educational programming annually.

If you have questions about our comments or require additional information, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961 or Casey Schwarz, Senior Counsel for Education and Federal Policy, at cschwarz@medicarerights.org or 212-204-6271.

II. Provisions of the Proposed Rule for the Physician Fee Schedule

E. Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services

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We applaud the Centers for Medicare & Medicaid Services' (CMS) recognition of care management as a critical component of primary care and its commitment to altering payment accordingly. We appreciate the steps CMS has already taken to refine the Physician Fee Schedule (PFS) to appropriately value care management (for example, by paying separately for transitional care management and chronic care management) and the continued commitment reflected in this year's proposed fee schedule. We support adjustments to codes to reflect more accurately the extensive cognitive work and increased interdisciplinary collaboration required in chronic care management.

Specifically we support CMS's proposals to:

- Improve payment for care management services provided in the care of beneficiaries with behavioral health conditions (including services for substance use disorder treatment) through new coding;
- Improve payment for cognition and functional assessment and care planning for beneficiaries with cognitive impairment;
- Adjust payment for routine visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities;
- Recognize for Medicare payment the additional CPT codes within the Chronic Care Management family (for Complex CCM services) and adjust payment for the visit during which CCM services are initiated (the initiating CCM visit) to reflect resources associated with the assessment for, and development of, a new care plan; and
- Recognize for Medicare payment CPT codes for non-face-to-face Prolonged Evaluation and Management (E/M) services by the physician (or other billing practitioner) that are currently bundled, and increase payment rates for face-to-face prolonged E/M services by the physician (or other billing practitioner) based on existing RUC recommended values.¹

The proposal to adjust payment for routine visits furnished to beneficiaries whose care requires additional resources is an important step to reduce real barriers to accessing care that many people with disabilities face.² Yet, these limitations are not only applicable to those with mobility-related disabilities. Recent Department of Justice settlements with healthcare providers name Americans with Disabilities Act (ADA) violations relating to both mobility and non-mobility related disabilities, including communication-related impairments.³ Although non-discrimination and access obligations under the ADA are not dependent on increased payment through the fee schedule, we encourage CMS to examine whether payment adjustments to address increased resource requirements for beneficiaries with non-mobility related disabilities are warranted.

¹ Department of Health and Human Services Centers for Medicare & Medicaid Services, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Proposed Rules, 81 Fed. Reg. 46201 (July 15, 2016).

² 6 Tara Lagu et al., Access to Subspecialty Care for Patients With Mobility Impairment: A Survey *Ann Intern Med* 19 March 2013: Vol. 158, No. 158, pp. 441-446, <http://annals.org/article.aspx?articleid=1667265>.

³ Dept. of Justice, Press Release "Justice Department Reaches Settlements with Multiple Health Care Providers to Stop Discrimination Against Persons with Disabilities Under the Barrier Free Health Care Initiative," July 20, 2015, <https://www.justice.gov/opa/pr/justice-department-reaches-settlements-multiple-health-care-providers-stop-discrimination>.

We also urge CMS to continue to pursue payment changes that reflect and recognize the activities and effort physicians and other practitioners dedicate to partnering with patients and families in managing care. The most effective care management activities are done in partnership and collaboration with patients (and as appropriate, family caregivers). When done well, partnering with patients and families on these activities may require additional time and resources on the part of clinicians, but yield more successful care management strategies that better meet the needs of patients and families and lead to better health outcomes. To this end, we encourage CMS to consider codes that reflect the additional time required to collaborate with patients and families. To ensure meaningful engagement and to avoid gaming or abuse, such codes should be accompanied by appropriate consumer protections and by robust quality metrics that emphasize patient-reported outcomes and experience.

These consumer protections should include documentation of conversations about care planning costs and cost sharing, mandatory documentation of privacy decisions, and mechanisms for patient feedback. We continue to encourage CMS to closely monitor concierge and other extra services physician arrangements. As enhanced care coordination is increasingly compensated for under the Medicare PFS, concierge arraignments that offer only this additional benefit may no longer be appropriate under the Office of the Inspector General (OIG) rules.

We strongly support efforts to reward physicians for inter-professional consultations and collaboration, especially between primary care and specialist providers. Yet, we believe that beneficiaries should be fully aware of the involvement of specialists in their care, as well as the associated benefits and costs of the collaboration between the beneficiary's primary care provider and a specialist. Therefore, we support the proposed requirements related disclosure and consent, and the reminder that general privacy protections remain in place.

We also support requiring integration of health information technology into collaboration efforts undertaken by primary care and specialist providers. Specifically, as part of collaborative care/care management services, we suggest that CMS implement similar requirements to those proposed for the Meaningful Use program: providers should be encouraged to electronically send "summary of care" documents and to incorporate these documents into transitions of care.

Finally, as we transition into new delivery system models that emphasize team-based care, we note that, in the future, these electronic platforms can support collaborative care by connecting all individuals involved in the care of a beneficiary—including their providers, social supports, family members, and beneficiaries themselves—in the collective work towards individually-identified goals. As the field of collaborative care evolves, we encourage CMS to look to future uses of technologies like electronic platforms and applications to support partnerships between beneficiaries, families, and their care team.

III. Other Provisions of the Proposed Rule for PFS

E. Release of Part C Medicare Advantage Bid Pricing Data and Part C and Part D Medical Loss Ratio (MLR) Data

CMS proposes to release to the public Medicare Advantage (MA) bid pricing data and Part C and Part D Medical Loss Ratio (MLR) data. We strongly support this proposal to increase transparency and public accountability with respect to plan costs. As described in the proposed rule, CMS has the authority to use information collected under certain provisions of the law for the purposes of improving public health through research on the utilization, safety, effectiveness, quality, and efficiency of health care services. The proposed regulation clearly identifies the categories of data that will be released and will standardize the disclosure and the procedures for disclosure in the interest of furthering goals related to the MA and Part D programs.

The purposes underlying the proposed releases, namely to allow public evaluation of the MA and Part D programs, to encourage research into these programs, and to make federal expenditures and other statistics involving these programs transparent to the public, are essential to the mission of the Medicare program. We agree that facilitating public research using this data could lead to “better understanding of the costs and utilization trends in MA and support future policymaking for the MA program.”⁴ We agree that enhanced transparency and understanding of health care utilization patterns across geographic and beneficiary population differences and how managed care in the Medicare population differs from and is similar to managed care in other populations can inform the future administration of the Medicare program.

We also agree that this disclosure is consistent with the Administration’s initiatives to improve management and transparency of federal information as outlined in the President’s January 21, 2009, “Memorandum on Transparency and Open Government”, which⁵ instructed federal agencies to take specific actions to implement increased data transparency and access to federal datasets. The White House has demonstrated a steady commitment to making information about government activities and government spending available to the public—which we strongly support. CMS’ proposal would promote accountability in the MA and Part D programs, by making MLR information publicly available for use by beneficiaries who are making enrollment choices and by allowing the public to see whether and how privately-operated MA organizations and Part D sponsors administer Medicare and supplemental benefits in an effective and efficient manner.

We appreciate CMS’ desire to balance these critical public interests with the need to protect the privacy of individuals, the confidentiality of information about Medicare beneficiaries, and the proprietary interests of the MA organizations and Part D sponsors. We agree that some of the information collected, particularly information that includes identifiable health or other beneficiary information, should be removed prior to publication.

⁴ 81 Fed. Reg. 46396.

⁵ 74 Fed. Reg. 4685.

Yet, we are concerned that certain aspects of CMS' proposal will limit the dissemination of useful information. Specifically, we encourage CMS to consider releasing data that is more recent and therefore more useful to beneficiaries and researchers. Given profound transformations in the health care system at large data from 2011 is unlikely to be as useful to researchers, and is even less likely to be of any significant use to beneficiaries.

F. Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing

We appreciate CMS' reminder to all Medicare providers (including providers of services defined in section 1861 of the Act and physicians) that federal law prohibits them from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments, from beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB) program (a Medicaid program which helps certain low-income individuals with Medicare cost-sharing liability). As noted in a memorandum provided to the Medicare Medicaid Coordination Office (MMCO) in June 2016, our experience aligns with CMS' findings in their July 2015 study, which found that that confusion and inappropriate balance billing persist notwithstanding laws prohibiting Medicare cost-sharing charges for QMB individuals.⁶ There is a significant need to re-educate, and continually remind, providers about proper billing practices for QMB enrollees. We agree with CMS that "providers should take steps to educate themselves and their staff about QMB billing prohibitions and to exempt QMB individuals from impermissible Medicare cost-sharing billing and related collection efforts."⁷ Additionally, we applaud CMS' reminder that the CY 2017 Medicare Advantage Call Letter reiterates the billing prohibitions applicable to dual eligible beneficiaries (including QMBs) enrolled in Medicare Advantage plans and the responsibility of plans to adopt certain measures to protect dual eligible beneficiaries from unauthorized charges under § 422.504(g).⁸

I. Medicare Advantage Provider Enrollment

While Medicare Rights supports the goals of the MA Provider Enrollment proposal, as we do the Part D Provider Enrollment program currently scheduled to be implemented in 2017, we have some concerns about access to care during the implementation and transition periods. Ensuring that all providers who serve Medicare beneficiaries are qualified providers is an important step in preventing fraud, waste, and abuse.

Yet, as we observed in Part D, it is a significant undertaking to conduct outreach and education to—and to enroll—health care providers who do not generally receive Medicare payment for the services they provide. As such, we encourage CMS to create realistic timeframes for implementation of these requirements, comprehensive outreach plans, and to implement beneficiary financial protections during the transition.

⁶ Medicare and Medicaid Coordination Office, Access to Care Issues Among Qualified Medicare Beneficiaries (QMB) ("Access to Care"), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

⁷ 81 Fed. Reg. 46407.

⁸ Centers for Medicare and Medicaid Services, 2017 Call Letter, p. 181-183, <https://www.cms.gov/Medicare/HealthPlans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>

J. Proposed Expansion of the Diabetes Prevention Program (DPP) Model

We strongly support CMS' recommendation to expand the Diabetes Prevention Program (DPP) into Medicare. The model has great potential to reduce Medicare spending while helping empower consumers to improve their health. The program expansion is especially positive given the emphasis the program places on engaging consumers in their own health care and the potential to utilize community settings and diverse providers, such as community health workers in the program's implementation. We look forward to further rulemaking on the program and encourage CMS to preserve the program's emphasis on patient engagement and community linkages that have made it so successful.

K. Medicare Shared Savings Program

2. Proposals

F. Alignment with Quality Payment Program

4. Incorporating Beneficiary Preference Into ACO Assignment

CMS proposes to expand upon the Pioneer Model Accountable Care Organization's (ACO) testing of mechanisms to incorporate beneficiary preference into certain ACO assignments. We appreciate that CMS acknowledges that beneficiary experience with the tested mailings for voluntary alignment have been mixed, and that efforts have been made to learn from beneficiary challenges with initial experiences.

In order to improve upon those experiences, CMS proposes both an enhanced manual process, by which beneficiaries send responses to a mailed request to CMS or to their ACO who then transmits that information to CMS, and an automated process by which beneficiaries select their "main" doctor through myMedicare.gov or other CMS controlled portal. We support the testing of both of these models to determine which approach presents lower burden for providers, CMS, and, most importantly, to Medicare beneficiaries.

Whichever approach is pursued, CMS should solicit significant input from beneficiary advocates, health care providers and others in developing the materials, should focus group test the materials and selection language, and utilize the strong infrastructure already in place to address beneficiary questions and concerns, including State Health Insurance Assistance Programs (SHIPs), as partners for information sharing.

Beneficiaries should receive clear, detailed information about the ACO assignment process, participating providers, information about how care will be better coordinated within integrated systems as well as risks of participation, and their rights and protections. This information should be presented in culturally and linguistically appropriate ways, taking into account the health literacy levels of consumers and assistive or alternative communication needs.

3. SNF 3-Day Rule Waiver Beneficiary Protections

CMS proposes to introduce two protections for beneficiaries who may receive SNF services without a three day stay who are later found to be ineligible for the waiver of this rule. First, CMS proposes to modify the waiver to include a 90-day grace period that would permit payment for SNF services provided to beneficiaries who were initially on the ACO's prospective assignment list for a performance year but were subsequently excluded during the performance year.

Second, CMS proposes to add requirements that would apply to SNF services furnished by a SNF affiliate that would otherwise have been covered except for the lack of a qualifying hospital stay preceding the admission to the SNF affiliate.

Medicare Rights supports these enhanced protections for beneficiaries who receive SNF services they may believe will be covered under the ACO waiver. The underlying 3-day stay rule can be confusing for beneficiaries, as can ACO assignment. We welcome CMS' recognition of the fact that the SNF and the ACO are better situated to know the waiver requirements and whether a beneficiary's situation fulfills them.

We encourage CMS to go further, however, and to modify the existing financial protections in the Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections at 70.2.2.2 which states that SNF Advance Beneficiary Notices (SNFABN) should not be given where Medicare is expected to deny a claim "because it does not meet a technical benefit requirement (e.g., SNF stay not preceded by the required prior three-day hospital stay)."⁹ Because given these waiver provisions, the three-day hospital stay requirement is not universal, this general rule with regard to SNFABNs should be revisited.

⁹ Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Ch. 30, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf>